STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185432	A. BUILDING _____ B. WING _____	08/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS REGIONAL MEDICAL CENTER	5000 KY ROUTE 321 PRESTONSBURG, KY 41653

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F 000	INITIAL COMMENTS A standard survey was conducted on August 3-4, 2010. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	1. Straws were immediately removed from the resident's room. Verbal and written information on providing thickened liquids were provided and reviewed with the resident and family members. The care plan was immediately updated to include dysphasia risk including administration of thickened liquids. The care plan was reviewed by all staff members. 2. All residents charts were reviewed for dysphasia risk and dietary restrictions. No additional problems were identified. Staff members were accessed for their current knowledge of the process for protecting patients with aspiration risk and administering thickened liquids. Written information was provided for immediate reference. 3. A meeting was held with the Director of Food Service, the senior Dietician and the Director of Education for the purpose of developing an educational program on assessing dysphagia risk and the process of administering thickened liquids.	8/31/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services to meet professional standards of quality for one (1) of ten (10) sampled residents. Resident #2 was assessed to need a pureed diet with nectar-thickened liquids, and no straws were to be used due to swallowing difficulty. However, during the medication pass observed on August 3, 2010, the facility staff nurse was observed to give the resident fluids with a straw. The findings include: A review of the medical record revealed a dysphagia evaluation was conducted for resident #2 by the Speech Therapist (ST) on August 2, 2010. A review of the dysphagia evaluation revealed resident #2 was assessed to have oral dysphagia with signs/symptoms of pharyngeal dysphagia. The ST recommended changing the resident's diet order to puree with nectar-thick liquids and to provide single bites/sips with no straws. A physician's order was obtained on August 2, 2010, for these recommendations. Resident #2 was observed on August 3, 2010, at	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sharon Vinyard for MSN CCRN Support Care Administrator Highlands Regional 8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 1:30 p.m., to be lying abed. A sign was posted above the resident's bed that directed thick liquids and no straws. During the medication administration observation conducted on August 3, 2010, at 4:50 p.m., the Licensed Practical Nurse (LPN) was observed to administer oral medications to resident #2. The LPN was observed to thicken the resident's water with a thickener at the resident's bedside and then gave the resident fluids using a straw. An interview conducted with the LPN on August 3, 2010, at 6:00 p.m., revealed the LPN was aware of the physician's order for thick liquids and no straws for resident #2. The LPN stated the ST had trained the staff and the resident's family. A review of the facility's policy/procedure related to physician's orders revealed the Licensed Nurses are responsible for the receipt and implementation of resident care orders based upon the individual's educational preparation and nursing experience.	F 281	3. (cont) The program will be presented in the August staff meeting on the Support Care Unit. It will be required for all new hires and annually for all staff. 4. The Support Care Clinical Manager will collaborate daily with the Dietician and Speech Therapist to monitor dysphasia assessment, care planning, and administering of thickened liquids to evaluate the compliance of staff with the process.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 323		

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F 323	Continued From page 2 review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible. On August 4, 2010, observation of the water temperature in the Central Bath Rooms revealed the facility failed to maintain safe water temperatures. The findings include: Observation of the two facility Central Bath Rooms on August 4, 2010, at 3:35 p.m., revealed the water temperature in the bath/shower rooms was 116 to 118 degrees Fahrenheit. An interview with the Maintenance Director on August 4, 2010, at 3:50 p.m., revealed the water temperature at the master regulator was set at 115 degrees Fahrenheit because the Maintenance Director believed the appropriate temperature range for the facility water was up to 115 degrees Fahrenheit. The Maintenance Director further stated the water temperatures were monitored monthly. A review of the water temperature logs revealed on July 26, 2010, temperatures in nine resident rooms ranged from 105 to 122 degrees Fahrenheit.	F 323	1. The Director of Facility Services was immediately notified of the elevated water temperature. Written standard for acceptable water temp was reviewed. 2. The Director of Facilities immediately had all domestic hot water mixing valves adjusted to the proper setting of 105 degrees. 3. The Support Care patient rooms are inspected monthly by Facility Services and water temp is logged. Any temps over 110 degrees during the monthly inspection will be immediately rectified and noted on room Inspection Form. The Support Care Manager and Director of Facilities will be notified of all out of range water temperatures.	8/31/10
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 332	4. The Director of Facility Services will be responsible for monitoring and maintaining correct water temp on the Support Care Unit.	

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F 332	Continued From page 3 review, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. The facility was assessed three (3) medication errors out of forty-seven (47) opportunities, for a medication error rate of 6.3 percent. The findings include: 1. During observation of the medication pass on August 3, 2010, at 5:17 p.m., the LPN was observed to administer Reglan 10 milligrams (mg) to resident #4. Resident #4 was observed at the time of medication administration to be sitting up in a chair by the resident's bedside. The resident's dinner meal tray was observed to be sitting on the overbed table and the resident stated the resident had completed the evening meal. A review of resident #4's physician's orders revealed Reglan 10 mg was ordered to be administered before meals and at bedtime. However, the medication was not provided to resident #4 until after the meal had been consumed. As a result, the facility was cited one medication error. Interview conducted on August 3, 2010, at 6:00 p.m., with the LPN revealed the LPN was aware the Reglan was ordered by the physician to be administered before meals to resident #4. The LPN stated the LPN should have given the medication to resident #4 before the resident consumed the evening meal. A review of the facility's policy/procedure related to medication administration revealed medications ordered to be administered before	F 332	1. Timeliness of medication administration per policy was discussed with responsible nurse and resident #4's chart was reviewed. No further omissions/errors were identified. Formal disciplinary action regarding medication timeliness and appropriate response to a medication error was initiated by the unit manager. 2. All residents' medication administration charts were reviewed by the Charge Nurse to monitor completeness. No further errors were identified. 3. The responsible nurse was educated regarding medication timeliness per HRMC policy. Alternative methods of accomplishing timely administration were discussed with Support Care staff, Unit Manager, and Pharmacy. Nurses were encouraged to ask for help from the Charge Nurse or Manager to accomplish timely administration. All staff will check to ensure that all medications ordered "before meals" have been administered before serving trays. 4. The Support Care Unit Manager will make medication	8/31/10

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F 332	Continued From page 4 meals were to be administered at 7:30 a.m., 11:30 a.m., and 4:30 p.m. (30 minutes before the meal was served). 2. A review of resident #6's physician's orders revealed Doribex 500 mg was ordered to be administered IV to resident #6 every eight hours. In addition, the resident had a physician's order to receive Clindamycin 900 mg IV every eight hours. According to the medication administration record, both of these medications were scheduled to be administered at 8:00 a.m., 4:00 p.m., and 12:00 a.m. Both of these medications were administered one and one-half to two and one-half hours late to resident #6 and the facility was assessed to have two medication errors. During the medication observation pass conducted on August 3, 2010, at 5:30 p.m., the LPN was observed to administer Doribex 500 mg mixed in 100 ml of 0.9% Sodium Chloride intravenously (IV) to resident #6. The LPN was observed to connect the IV tubing into an IV pump and set the medication to infuse over one hour. An interview conducted with the LPN on August 3, 2010, at 6:00 p.m., revealed the LPN was aware both of the IV medications were scheduled to be administered at 4:00 p.m. to resident #6. The LPN stated the medication was late because the resident had gone downstairs to smoke. The LPN stated since the Doribex was not administered until 5:30 p.m., the Clindamycin would not be administered until 6:30 p.m., after the Doribex had infused. The LPN further stated the LPN should have reminded the resident of the timeframes for these medications and the benefits of maintaining the scheduled times for	F 332	4. (cont) rounds weekly to monitor for compliance of medication timeliness. 1. The physician of resident #6 was notified of the medication error, orders received and carried out by the responsible nurse. 2. All residents' medication administration charts were reviewed for timeliness and/or conflicting administration schedules. 3. The error was reviewed by the Support Care Administrator with the responsible nurse, the Charge Nurse, SC Manager, and Pharmacist. The process of scheduling IV medications was discussed. The Pharmacy will change the standard administration times for multiple IV piggybacks in order to provide an accurate individualized administration schedule for each resident's medications. Staff members were instructed to review medication administration times with the residents to ensure their availability throughout the shift. 4. The process change will be monitored by the Pharmacy staff for compliance and timeliness. The results	8/31/10

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F 332	Continued From page 5 administration. An interview conducted with the Clinical Manager (CM) on August 4, 2010, at 2:25 p.m., revealed the LPN should have started the medications 30 minutes to one hour prior to the scheduled time in order to meet the timeframe for these medications.	F 332	4. (cont) will be reported to the Support Care Manager. 1. The Director of Food Services was made aware of missing food items from residents' trays. The missing items were delivered immediately. Tray line staff were made aware of the omission. The dietary clerk responsible received a verbal counseling. 2. All residents' trays were checked for accuracy by the Food Services staff. No further omissions were identified. 3. Findings of State survey results will be shared with all staff in the August staff meeting. All trays will be checked for accuracy prior to delivery to the Support Care Unit. Dietary Stores clerk will check daily to ensure all items on resident's menu are in stock. Monthly in-services and training will be held with diet clerks to include importance of tray accuracy, modifying menus,	8/31/10
F 363 SS=B	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow the planned menu for the evening meal on August 4, 2010, for four (4) residents related to cranberry sauce (residents #1, #8, #9, and #10) and for one resident (resident #1) related to peas/carrots. The findings include: Review of the planned menu spreadsheet specified that residents required to receive regular, soft/bland, or sodium-controlled diets were to receive one ounce of cranberry sauce with the evening meal on August 4, 2010. Observation of the evening meal on August 4, 2010, at 4:20 p.m., revealed cranberry sauce was	F 363		

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F 363	Continued From page 6 not available in the tray preparation area and had not been placed on residents #8, #9, and #10's food tray. Interview with one of the dietary staff members preparing meal trays on August 4, 2010, at 4:20 p.m., revealed the facility did not have any cranberry sauce. The Food Service Director was present during the interview, and obtained cranberry sauce from the food court, where visitors/employees ate. However, dietary staff failed to place cranberry sauce on residents #8, #9, and #10's meal trays after the cranberry sauce was obtained by the Food Service Director. Further review of the planned menu spreadsheet revealed residents who required a calorie-controlled diet were not to receive cranberry sauce and were required to receive one-half cup of peas and carrots. However, further observation of the evening meal on August 4, 2010, at 4:20 p.m., revealed resident #1, who was on a calorie-controlled diet, received cranberry sauce and did not receive any peas and carrots. An interview with the Food Service Director on August 4, 2010, at 5:15 p.m., revealed the diet clerk made a mistake by putting cranberry sauce on resident #1's food tray. According to the Food Service Director, the cook was nervous and forgot to put peas and carrots on resident #1's food tray.	F 363	3. (cont) and food substitutions. 4. Dietary staff will incorporate accuracy checks for Support Care Unit trays into the monthly test tray schedule. Accuracy of trays to be monitored/maintained by the Food Service Director. Results will be forwarded to the Support Care Unit Manager.	
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	1. All kitchen and hallway floors were cleaned within two hours of the initial recommendation. 2. The Housekeeping Director formulated an action plan	8/31/10

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F 465	Continued From page 7 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary environment for residents and staff. On August 4 and 5, 2010, the floor in the tray preparation area of the Dietary Department was observed to be soiled and in need of cleaning. The findings include: Observation of the floor in the Dietary Department on August 4, 20010, at 1:00 p.m. and 4:20 p.m., and on August 5, 2010, at 8:50 a.m., revealed the floor in the tray preparation area was dirty with a buildup of dirt and debris around the edges of the floor and baseboard. An interview with the Food Service Director on August 5, 2010, at 2:30 p.m., revealed the Housekeeping Department cleaned the floors nightly Monday thru Friday. However, according to the Food Service Director, a new staff member had been hired in the previous few weeks and had not been cleaning the floors in the tray preparation area because the staff member did not realize the tray preparation area was part of the kitchen.	F 465	2. (cont) for immediate and ongoing maintenance of all areas of the kitchen with the approval of the Director of Food Service and the Chief Operating Officer. 3. A daily maintenance plan was developed to include dust mop, wet mop, and auto scrub of the kitchen floor, the entrance way, and corridor. All floor surfaces in the kitchen area are to be cleaned, stripped, and waxed before the end of August. 4. Monitoring will be performed by the Housekeeping Supervisor to ensure compliance. The Director of Food Service will report any deficient practices to the Director of Housekeeping and the Chief Operating Officer immediately.	